

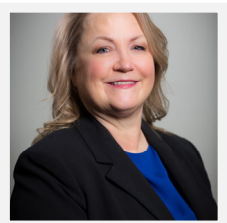




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Our Panel



	
Host	Panelist
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SURVEY

CMS • ACHC • CHAP • TJC

Top Home Health Deficiencies

Building a Survey-Ready Agency in 2026

What the latest CMS, ACHC, and CHAP data tell us about where surveyors find agencies — and how to close those gaps before the unannounced visit.

READINESS

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GROUND THE TERMS

Three severity levels — three very different consequences

STANDARD-LEVEL	CONDITION-LEVEL	IMMEDIATE JEOPARDY
Single or few infractions of CMS standards. Does not cause failure or trigger resurvey.	Out of compliance with the majority of standards under a CoP, OR failure of a heavily weighted standard.	Direct threat to patient health and safety — actual or potential serious harm.
CONSEQUENCE	CONSEQUENCE	CONSEQUENCE
Document a Plan of Correction and move on.	Failure. Triggers resurvey within ~45 days.	\$500–\$21,800/day CMP. Fix in 23 days or face termination.

Standard surveys review Level 1 standards first. Noncompliance with a Level 1 standard can expand the survey to a partial extended or extended review of all CoPs.

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WHY THIS MATTERS

The cost of a single condition-level deficiency

1

deficient CoP

is all it takes to fail a Medicare survey

\$21,800

per day

maximum civil money penalty for an Immediate Jeopardy citation

23 days

to recover

from an IJ — submit a Plan of Correction and pass a follow-up survey

Surveys are unannounced. The work to pass one happens months before the surveyor arrives.

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CHAP DATA • CALENDAR YEAR 2025

Top 10 most-cited home health deficiencies

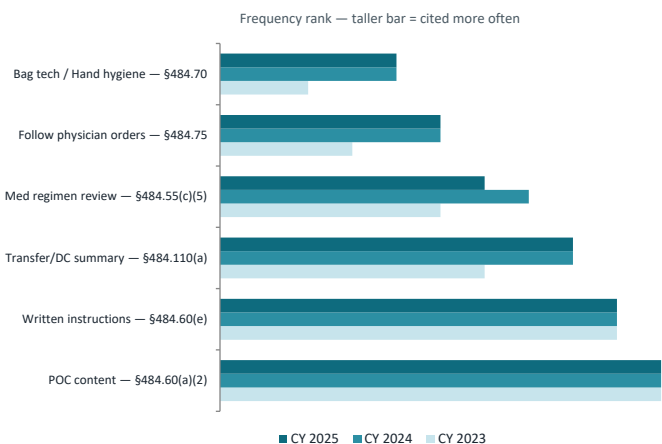
#	G-TAG	CFR CITATION	WHAT IT'S ABOUT
1	G574	§484.60(a)(2)	Content of the individualized plan of care
2	G614	§484.60(e)(2)	Written instructions to patient/caregiver including visit schedule
3	G1022	§484.110(a)(6)	Transfer/discharge summary in clinical record within required timeframe
4	G442	§484.50(c)(8)	Advance written notice before non-covered care or care reduction
5	G536	§484.55(c)(5)	Comprehensive assessment includes medication regimen review
6	G710	§484.75(b)	Skilled professionals follow plan of care and physician orders
7	G682	§484.70(a)	Bag technique to prevent spread of infection in the home
8	G682	§484.70(a)	Hand hygiene performed when indicated
9	G572	§484.60(c)(1)	Plan of care reviewed/ revised at minimum every 60 days
10	G808	§484.80(h)(1)	RN supervisory assessment of aide services every 14 days

■ Persistent top-2 citations across 2023, 2024, and 2025 — same standards every year • Source: CHAP

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TREND ANALYSIS • CY 2023 - CY 2025

The same problems are showing up year after year



STABLE AT THE TOP

Plan of Care content and written patient instructions have ranked #1 and #2 every year for three consecutive years.

RISING MID-TIER

Transfer/discharge summary timeliness moved from #5 (2023) to #3 (2024–2025). EMR workflow gap.

BEHAVIORAL FLOOR

Infection control (bag technique, hand hygiene) holds steady in the lower half — observational compliance, not policy.

Source: CHAP 2023–2025 Deficiency Comparison

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ACHC DATA • JUNE 2024 - MAY 2025

Documentation reliability tops the deficiency list

§484.110(a)

22%

of ACHC home health surveys

cited for incomplete, illegible, or unauthenticated patient record entries

What §484.110(a) requires

Clinical Records — every patient must have an individual record with documentation of every visit, treatment, or service. Entries must be legible, clear, complete, and properly authenticated, dated, and timed — with credentials.

What surveyors found

- Missing referral history, hospital stays, and reason for referral
- Visit notes lacking legible signatures with credentials
- Entries missing date, time, or both
- Incomplete documentation of treatments and services rendered

Encouraging trend: ACHC's top-eight standard average dropped from 41% (2022) to 32% (2025). Education works — but clinical record authentication is the lone holdout.

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WHAT EVERY ACCREDITOR IS FINDING

Six themes show up across CMS, CHAP, ACHC, and TJC

<p>Care Planning</p> <p>Generic, non-individualized POCs. Missing measurable goals tied to comprehensive assessment.</p> <p>§484.60(a)</p>	<p>Patient Communication</p> <p>Visit schedules, written instructions, and care-change notices not delivered or documented.</p> <p>§484.50(c) / §484.60(e)</p>	<p>Documentation Reliability</p> <p>Late, missing, or unauthenticated entries. Records that don't match the care delivered.</p> <p>§484.110(a)</p>
<p>Medication Management</p> <p>Med reg review missing OTCs, supplements, topicals. Discrepancies not reported to MD.</p> <p>§484.55(c)(5)</p>	<p>Infection Control</p> <p>Hand hygiene and bag technique observed in the field — behavioral lapses, not policy gaps.</p> <p>§484.70(a)</p>	<p>Aide Supervision</p> <p>14-day RN supervisory assessment skipped or undocumented. Aide notes don't track POC.</p> <p>§484.80(h)(1)</p>

Synthesis: CHAP 2025 Top 10 • ACHC Quality Review 2025 • Cross-AO common deficiencies (THHC, 2025)
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DEEP DIVE • THE #1 DEFICIENCY

Individualized Plan of Care — §484.60(a)(2) • G574

WHAT THE SURVEYOR SEES	WHAT KEEPS YOU COMPLIANT
<ul style="list-style-type: none"> POC goals are vague: "improve mobility," "increase strength" No measurable starting status or target outcome Interventions don't link to comprehensive assessment findings Disciplines, supplies, or visit frequencies missing from orders Care plan not reviewed every 60 days as required (§484.60(c)(1)) 	<ul style="list-style-type: none"> SMART goals with specific starting status, target, and due date Tie every intervention back to an assessment finding (e.g., M1840) Include all ordered disciplines, services, supplies, and frequencies Build a patient narrative section — diagnoses, history, living situation POC audit at SOC, recert, and any significant change in condition

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Documentation timeliness and medication regimen review

DOCUMENTATION TIMELINESS

Late notes, missing visits, records that don't support the care provided

Practical levers

- Hold pay until visit + documentation are complete — "the job is both"
- Daily follow-up call from a designated documentation coordinator
- EMR alerts for missing meds, allergies, or interventions
- On-time bonus (\$1–\$5 per timely submission) and same-day audit feedback
- Required first-hour office documentation for full-time field staff

MEDICATION REGIMEN REVIEW

§484.55(c)(5) • Comprehensive assessment must include a med regimen review

Capture for every medication

- Full name as written on the bottle, dosage, route, frequency
- Start date and end date (if applicable), special instructions
- PRN indicators clearly noted on the medication profile
- OTCs, eye drops, creams, supplements, injections, and topicals
- Reconcile every visit — report discrepancies to MD and document

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Infection control and home health aide supervision

INFECTION CONTROL • §484.70(a)

Hand hygiene + bag technique are observed during home visits

Behavioral compliance, not paperwork

- Annual competency check + bag technique demo at hire
- Surprise hand hygiene observations whenever staff are in office
- Flag staff who needed multiple tries to pass — re-observe next round
- Standard precautions training documented and current for every clinician
- PPE accessible in field bags; replacement protocol audited

AIDE SUPERVISION • §484.80(h)(1)

RN supervisory assessment of aide services every 14 days

What surveyors verify

- Supervisory visit completed and documented within the 14-day window
- Aide care plan written with task-specific instructions — no "PRN"
- Aide notes correspond to assigned tasks on the aide care plan
- First aide note for each new patient is reviewed by the RN
- Refusals of care are documented and escalated to the office

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WHY THE SAME ISSUES KEEP RECURRING

Root causes behind year-over-year deficiency stability

01

EMR templates don't enforce required POC elements

Clinicians fill in what the form asks for. If the template is loose, the documentation is loose.

02

Onboarding skips the regulation behind the form

Staff are taught how to click, not why each field exists. Compliance becomes accidental.

03

Audits are reactive, not built into the workflow

Charts are reviewed when something goes wrong instead of as a routine quality discipline.

04

Field practice is rarely observed

Hand hygiene, bag technique, and patient education happen in the home — not on a screen the office can see.

05

Communication chains break at handoffs

MD orders, transfer summaries, and condition-change notifications are the most fragile links.

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BUILD AN ONGOING PROGRAM

What an effective mock survey actually looks like

1

Document Pull

Day 1

Pull the same package the surveyor gets — 855A, governing body minutes, OASIS validation reports, last 4 months of records.

2

Chart Review

Days 1–2

Stratified sample across active, recently discharged, transferred, and complaint cases. Score against G-tags.

3

Home Visits

Days 2–3

Observe hand hygiene, bag technique, patient education, and POC presence in the home folder.

4

Exit & POC

Day 3

Hold a real exit conference. Issue findings on a CMS-2567 format. Build a Plan of Correction with timelines and owners.

CADENCE

Quarterly mini-mocks • Annual full mock

Quarterly mocks focus on a single CoP rotation. The annual full mock simulates the real survey end-to-end with at least one outside reviewer.

SCOPE PRIORITY

Audit Level 1 standards first

Standard surveys review Level 1 first. Build your audit tool around them — POC content, comprehensive assessment, infection control, aide supervision, and emergency preparedness.

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ACTION PLAN

90-day path to defensible survey readiness

DAYS 1-30	DAYS 31-60	DAYS 61-90
<p>Diagnose</p> <ul style="list-style-type: none"> Pull last CMS-2567 and any complaint histories Run a 20-chart POC audit against G574 elements Map current EMR templates against required fields Survey staff: which CoPs feel weakest in your agency? Assemble survey binder: 855A, OASIS validation reports, governing body minutes 	<p>Fix</p> <ul style="list-style-type: none"> Update EMR templates to enforce POC, med profile, aide care plan fields Roll out hand hygiene + bag technique competencies for every clinician Stand up daily documentation follow-up (call list + dashboard) Create transfer/discharge summary tracker with 5-day deadline alerts Train clinical managers on G-tag-level chart review 	<p>Prove</p> <ul style="list-style-type: none"> Run a full mock survey — outside reviewer, exit conference, POC document Re-audit the same 20-chart POC sample for measurable improvement Field observation of 100% of clinical staff in patient homes Tabletop emergency preparedness drill with documentation Brief governing body on findings, plan of correction, and ongoing dashboards

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WHAT'S CHANGING

2026 regulatory environment to factor into prep

Jan 2025	<p>OASIS-E1 implemented</p> <p>All M0090 SOC dates ≥ Jan 1, 2025 use the OASIS-E1 instrument. Audit assessment accuracy as a standing item.</p>
Apr 2024	<p>Revised Appendix B Interpretive Guidelines</p> <p>CMS broadened surveyor reviews when an agency is out of compliance with a Level 1 standard. Three new emergency preparedness items added to standard Level 1 reviews.</p>
Jul 2025	<p>All-payer OASIS data collection</p> <p>Every qualified home health patient — regardless of payer — must have a complete OASIS. Data feeds HHQRP starting CY 2027.</p>
Jan 2026	<p>HHVBP measure set + weighting refresh</p> <p>Updated Large Cohort weights: OASIS 40%, Claims 40%, HHCAHPS 20%. Discharge Function Score and GG items carry more weight.</p>
Apr 2026	<p>OASIS-E2 + revised HHCAHPS</p> <p>Draft OASIS-E2 instruments released August 2025. Implementation planned for April 2026. HHCAHPS revised the same month.</p>

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KEY TAKEAWAYS

Five things to walk out with

- 1 The same standards top the deficiency list every year — Plan of Care content (§484.60(a)) and Patient Communication (§484.50(c) / §484.60(e)) are the two universal vulnerabilities.
- 2 Documentation reliability under §484.110(a) is now the highest ACHC finding (22% of surveys). Authentication, dating, and timing are non-negotiable basics.
- 3 Most repeat findings are workflow problems, not policy problems. Templates, audits, and field observation close the gap.
- 4 Mock surveys must include home visits — bag technique and hand hygiene under §484.70 are observed, not documented.
- 5 Build a 90-day cycle: diagnose, fix, prove. Re-audit the same charts to demonstrate measurable improvement.

J/non • Survey Readiness Training Series • 2026

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REFERENCES & DISCUSSION

Sources and where to go deeper

QUESTIONS?

Discussion + Audit Walk-through

PRIMARY SOURCES

CHAP 2023–2025 Deficiency Comparison

chapinc.org • Resources & Survey Readiness • January 2026

ACHC Surveyor Newsletter — Quality Review 2025

achc.org • Volume 2025 No. 2 • data through May 31, 2025

CMS State Operations Manual, Appendix B

cms.gov • Guidance to Surveyors: Home Health Agencies, Rev. April 2024

QSO-24-07-HHA — HHA Survey Process

cms.gov • Quality, Safety & Oversight Group, March 2024

FY26 SPSS Performance Standards

cms.gov • Admin Info 26-02, January 2026

42 CFR Part 484 — HHA Conditions of Participation

efjr.gov • Subpart B (CoPs) and Subpart I (survey/certification)

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April Scenario Answer

Scenario: Your home health agency completes a Recertification OASIS on Day 52 of the current certification period due to a scheduling conflict. The assessment is submitted, and services continue without interruption. A week later, your agency realizes the assessment was completed outside of the allowed recertification window (Days 56–60).

What should the agency do next?

- A. Complete a new Recertification OASIS as soon as possible, even if it is late
- B. Leave the assessment as is, since it was submitted
- C. Edit the assessment date to fall within Days 56–60 and resubmit
- D. Discharge and readmit the patient to establish a new certification period

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April Scenario Answer Rationale

Official Answer:

Whenever you discover that you have missed completing a recertification assessment within the required timeframe (days 56-60), you should not discharge that patient and readmit or use an assessment that was completed prior to the required assessment window. As soon as you realize that you missed the recert window, conduct a recertification comprehensive assessment including OASIS. You will receive a warning message when submitting the assessment.

Q11.2. CMS OASIS Q&AS - Category 3 - Follow-Up Assessments released February 2026

https://qtso.cms.gov/system/files/qtso/Category%203_Follow-Up%20Assessments_0.pdf

Official Answer:

When an agency does not complete a recertification assessment within the required 5-day window at the end of the certification period, the agency should not discharge and readmit the patient. Rather, the agency should send a clinician to perform the recertification assessment as soon as the oversight is identified. The date assessment completed (M0090) should be reported as the actual date the assessment is completed, with documentation in the clinical record of the circumstances surrounding the late completion. A warning message will result from the non-compliant assessment date, but this will not prevent assessment transmission. No time frame has been set after which it would be too late to complete this late assessment, but the agency is encouraged to make a correction or complete a missed assessment as soon as possible after the oversight is identified. This situation should be avoided, as it does demonstrate non-compliance with the comprehensive assessment update standard (of the Conditions of Participation). For the Medicare PPS (PDGM) patient, payment implications may arise from this missed assessment. Any payment implications must be discussed with the agency's Medicare Administrative Coordinator (MAC).

From the OASIS-E2 Guidance manual, M0100: Assessment Reason, Recertification (Follow-Up) RFA 4 pg. 47

<https://www.cms.gov/files/document/oasis-e2-draft-508-11-14-25.pdf>

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May Scenario

Scenario: A Start of Care clinician completes medication reconciliation using the hospital discharge summary and confirms prescription bottles in the home. During survey, the patient reports taking several supplements and PRN OTC medications not listed in the chart.

Which statement is most accurate?

- A. Prescription medications are the only items required for reconciliation.
- B. All items the patient takes should be reviewed and documented.
- C. Supplements are only listed when ordered by a physician.
- D. OTC medications are optional unless side effects occur.



Product Spotlight

Product Spotlight

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What's new with AHCC

AHCC Educational call June 24

- Hospice coding and the HOPE tool.



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